

Wendy Littner Thomson, M.Ed., LPC, CGCS, RYT
 Counseling Services
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 Bethlehem, PA 18018
 610-730-1992
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Please fill in the information below and return it to me. Once it is received, we will be able to schedule your first counseling appointment. Please note that information provided on this form is considered protected as confidential information.

Personal Information:

Name: (Nickname or Preferred Name, if applicable):			
Date:	Parent/Legal Guardian (if under 18):		
Address (Street):			
(City, State, Zip code):			
Home Phone:	May we leave a message? Circle: Yes No		
Cell/Work/Other Phone:	May we leave a message? Circle: Yes No		
Email: <i>(Please Note: Email is not considered to be a confidential medium of communication).</i>			
DOB:	Age:	Gender:	
Marital Status: (Circle)	Never married	Domestic Partnership	Married
Separated	Divorced	Widowed	Other
If any, who do you consider to be family or significant people in your life?			
Referred By (if any) or how did you find our Counseling Services?			

Mental Health History:

Have you previously received any type of mental health services (e.g., psychotherapy, psychiatric services, in-patient treatment services, out-patient treatment services, etc.)? Circle: No Yes (Previous therapist or practitioner, or Explain):
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<p>Are you currently taking any prescription medications? Circle: No Yes (If yes, please list, along with any side effects you are aware of):</p> <p>Have you ever been prescribed psychiatric medication? Circle: No Yes (If yes, please list and provide dates. If continuing, who is managing your medication?)</p>
<p>Have you been diagnosed with a thyroid imbalance? Circle: No Yes (If yes, are you taking medication to address this condition and, if so, who is managing your condition and medication?)</p>

General and Mental Health Information:

<p>1. How would you rate your current physical health? Circle: Poor Unsatisfactory Satisfactory Good Very Good</p> <p>Please list specific health problems you are currently experiencing:</p>
<p>2. How would you rate your current sleeping habits? Circle: Poor Unsatisfactory Satisfactory Good Very Good</p> <p>Please describe any specific sleep problems you are currently experiencing:</p>
<p>3. Generally, how many times per week do you exercise? What types of exercise do you participate in?</p> <p>On a scale of 1-10 (1=not important, 10=very important) how important is this to you?</p>
<p>4. Please list any difficulties you experience related to your diet and/or appetite. Do you have any food allergies or sensitivities that you're aware of?</p>
<p>5. Are you currently experiencing overwhelming sadness, grief or depression? Please circle. If yes, for approximately how long?</p>
<p>6. Are you currently experiencing anxiety, panic attacks or have any phobias? Please circle. If yes, when did you begin to experience this or these?</p>
<p>7. Are you experiencing any chronic pain? Circle: No Yes (If yes, please describe):</p>
<p>8. Do you drink alcohol more than twice a week? Circle: No Yes (If yes, please specify):</p>
<p>9. How often do you engage in recreational drug use? Circle: Daily Weekly Monthly Infrequently Never</p>

10. Are you currently in a romantic relationship? Circle: No Yes If yes, for how long? On a scale of 1-10 (1=poor, 10=exceptional), how would you rate your relationship?
11. What significant life changes or stressful events have you experienced recently?
12. If you are coming to Counseling due to a recent loss, please specify (including the date(s) of the loss(es):

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, grandmother, uncle, etc.)

Mental Health Concern	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obesity	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts/Suicide	Yes/No	

Additional Information:

1. Are you currently employed? Circle: No Yes
If yes, what is your current employment situation?
Do you enjoy your work? Is there anything stressful about your work situation? (Please describe):
If not currently employed, what was your livelihood?
Is your current non-work situation "satisfying enough?"
2. Do you consider yourself to be spiritual or religious or both? Please circle and if applicable, briefly describe your faith, belief or philosophy:
3. What do you consider to be some of your strengths?

4. What do you consider to be some of your non-strengths, what you struggle with, personal obstacles?

5. On a scale of 1-10 (1=poor, 10=strong), how would you rate your self-esteem?
Elaborate if you wish:

6. What would you like to accomplish in therapy?